# TENNESSEE DEPARTMENT OF HEALTH
# JOINT ANNUAL REPORT OF ASSISTED-CARE LIVING FACILITIES
# 2005

## SCHEDULE A - IDENTIFICATION

1. Name of Facility _____
2. Address: Street _____
   City _____ State _____ Zip Code _____
3. Telephone Number: (___)_____
4. Ownership of Building: Name _____
   Address _____
   City _____
   State _____ Zip Code _____
5. Administrator _____Certification Number _____
6. Medical Director _____
7. Name of person(s) completing this form_____
8. Email address of person(s) completing this form _____
9. Reporting Period: Beginning Date _____ Ending Date _____

## SCHEDULE B – OWNERSHIP OF BUSINESS

1A. Check the type of legal entity:

_____ Individual _____ Partnership _____ Corporation

_____ Church related _____ Government/County _____ Other

B. Name of legal entity checked in 1A. _____

2A. Is this facility chain affiliated? ____Yes ____ No

B. If yes, list the name and address of the parent company.

Name _____

Street _____

City _____ State ____ Zip _____

3A. If a corporation, is there a holding company/parent corporation?

____Yes ____ No

B. If yes, list the name and address of holding company/parent corporation.

Name _____

## SCHEDULE B – OWNERSHIP OF BUSINESS (continued)

Street _____

City _____ State ____ Zip _____

4A. Do you have a contract with a management firm to operate this facility?

____Yes ____ No

B. If yes, list the name and address of the firm.

Name _____

Street _____

City _____ State ____ Zip _____

## SCHEDULE C – FACILITIES AND SERVICES

1. Facilities:
   A. Did your facility have new construction and/or services during the year that resulted in a change of the facility's licensed bed count?
   ____Yes ____ No
   B. Cost of new construction: _____
2. Services:
   A. Does the facility operate an adult day care center? ____Yes ____ No
   B. Does the facility provide respite care? ____Yes ____ No
   C. Does the facility have a specialized unit for Alzheimer's patients?
   ____Yes ____ No
   If yes, number of beds in that unit _____
   If no, does the facility have specialized programs for Alzheimer's patients? ____Yes ____ No

## SCHEDULE D – BEDS

1. Number of beds licensed as of 12/31:_____
2. Changes to licensed beds during calendar year:
   A. Did your facility have beds increased during year? ____Yes ____ No
   If yes, please provide the number of beds increased. _____
   Date _____
   B. Did your facility have beds decreased during year? ____Yes ____ No
   If yes, please provide the number of beds decreased. _____
   Date _____
3. On the last day of the reporting period how many beds in your facility were in each of the following types of rooms.

Private _____ Semi-Private _____

## SCHEDULE E – UTILIZATION

1. Please complete the following by giving number of admissions, discharges, deaths (January 1 – December 31), and number of discharge days.

| | Admissions | Discharges including Deaths | Deaths | Number of Discharge Days |
|---|---|---|---|---|
| Total | _____ | _____ | _____ | _____ |

2. How many residents have you transferred to a hospital (excluding deaths) during the past year? Include only residents for whom you held a bed.

_____

## **SCHEDULE E – UTILIZATION**(continued)

3. How many residents have you discharged (excluding deaths) to the following?

| Type | Number |
|---|---|
| A. Hospital (or transferred and did not return) | _____ |
| B. Home (private residence) | _____ |
| C. Residential Home for Aged | _____ |
| D. Nursing Home | _____ |
| E. Other Assisted-Care Living Facility | _____ |
| F. All other | _____ |
| G. Total | _____ |

4. How many resident days of care did you provide in the following categories?

| | |
|---|---|
| A. Self-Pay | _____ |
| B. Long-Term Care Insurance | _____ |
| C. Other | _____ |
| D. Total | _____ |

5. Number of residents in the facility on 12/31 by age, race, and sex:

| | White | | Black | | Other | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Male | Female | Male | Female | Male | Female | Male | Female |
| Under 60 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 60 to 64 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 65 to 69 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 70 to 74 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 75 to 79 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 80 to 84 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 85 to 89 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 90 to 94 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 95 to 99 years | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| 100 yrs & older | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| Total | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |

## **SCHEDULE E – UTILIZATION** (continued)

6. Please indicate for the residents in the facility on 12/31 the county or state of last residence. Note: Total residents must agree with the total in item 5.

| TN County Residence | Number of Residents | TN County Residence | Number of Residents |
|---|---|---|---|
| 01 Anderson | | 55 McNairy | |
| 02 Bedford | | 56 Macon | |
| 03 Benton | | 57 Madison | |
| 04 Bledsoe | | 58 Marion | |
| 05 Blount | | 59 Marshall | |
| 06 Bradley | | 60 Maury | |
| 07 Campbell | | 61 Meigs | |
| 08 Cannon | | 62 Monroe | |
| 09 Carroll | | 63 Montgomery | |
| 10 Carter | | 64 Moore | |
| 11 Cheatham | | 65 Morgan | |
| 12 Chester | | 66 Obion | |
| 13 Claiborne | | 67 Overton | |
| 14 Clay | | 68 Perry | |
| 15 Cocke | | 69 Pickett | |
| 16 Coffee | | 70 Polk | |
| 17 Crockett | | 71 Putnam | |
| 18 Cumberland | | 72 Rhea | |
| 19 Davidson | | 73 Roane | |
| 20 Decatur | | 74 Robertson | |
| 21 Dekalb | | 75 Rutherford | |
| 22 Dickson | | 76 Scott | |
| 23 Dyer | | 77 Sequatchie | |
| 24 Fayette | | 78 Sevier | |
| 25 Fentress | | 79 Shelby | |
| 26 Franklin | | 80 Smith | |
| 27 Gibson | | 81 Stewart | |
| 28 Giles | | 82 Sullivan | |
| 29 Grainger | | 83 Sumner | |
| 30 Greene | | 84 Tipton | |
| 31 Grundy | | 85 Trousdale | |
| 32 Hamblen | | 86 Unicoi | |
| 33 Hamilton | | 87 Union | |
| 34 Hancock | | 88 Van Buren | |
| 35 Hardeman | | 89 Warren | |
| 36 Hardin | | 90 Washington | |
| 37 Hawkins | | 91 Wayne | |
| 38 Haywood | | 92 Weakley | |
| 39 Henderson | | 93 White | |
| 40 Henry | | 94 Williamson | |
| 41 Hickman | | 95 Wilson | |
| 42 Houston | | 96 Unknown Counties | |
| 43 Humphreys | | STATES | |
| 44 Jackson | | 01 Alabama | |
| 45 Jefferson | | 04 Arkansas | |
| 46 Johnson | | 11 Georgia | |
| 47 Knox | | 18 Kentucky | |
| 48 Lake | | 25 Mississippi | |
| 49 Lauderdale | | 26 Missouri | |
| 50 Lawrence | | 34 North Carolina | |
| 51 Lewis | | 47 Virginia | |
| 52 Lincoln | | 55 Other States | |
| 53 Loudon | | | |
| 54 McMinn | | **Total** | |

## SCHEDULE F – PERSONNEL

1. Number of personnel on 12/31, by type:

Only report data for a type of employee for which you provide that type of service.

| | Facility Employees | | Employee Pool/Consultant | |
|---|---|---|---|---|
| Type of Employee | Full-Time | Part-Time in Full-Time Equivalent* | Full-Time | Part-Time in Full-Time Equivalent* |
| Administrators | | | | |
| Assistant Administrator | | | | |
| Registered Nurses | | | | |
| Licensed Practical Nurses | | | | |
| Nurses Aides & Orderlies | | | | |
| Dietary Managers | | | | |
| Registered Dietitians | | | | |
| Dietetic Technicians | | | | |
| Medical Social Workers | | | | |
| Social Workers | | | | |
| Activity Coordinators | | | | |
| Maintenance | | | | |
| Housekeeping | | | | |
| Other Health | | | | |
| Other Non-Health | | | | |
| Total | | | | |

*Full-time equivalent should be calculated as:

$$\frac{\text{Number of Hours worked by part-time employees per week}}{\text{40 hours per week}}$$

2. Please indicate the number of nursing personnel on duty on 12/31 (that is, on the premises and routinely serving the residents) for each shift. Do not include a person who is merely "on call."

A. Three Shifts

| | Shift #1 Day | Shift #2 Evenings | Shift #3 Night | Total |
|---|---|---|---|---|
| Registered Nurses | | | | |
| Licensed Practical Nurses | | | | |
| Aides and/or Orderlies | | | | |
| Total | | | | |

B. Two Shifts

| | Shift #1 Day | Shift #2 Evenings | Total |
|---|---|---|---|
| Registered Nurses | | | |
| Licensed Practical Nurses | | | |
| Aides and/or Orderlies | | | |
| Total | | | |

3. Does your facility provide the following employee benefits?

A. 401 K Plan _____Yes _____ No
B. Retirement Plan _____Yes _____ No
C. Health Insurance _____Yes _____ No
D. Life Insurance _____Yes _____ No

## SCHEDULE F – PERSONNEL (continued)

4. Nursing Personnel

A. Registered Nurses

| Highest Education Level | FTE Number Currently Employed | Number of Budgeted Vacancies | Number of Positions You Added in the Past 12 Months | Number of Positions You Eliminated in the Past 12 Months |
|---|---|---|---|---|
| Bachelors Degree | | | | |
| Associate Degree | | | | |
| 3 Year Diploma Nurse | | | | |
| Masters Degree | | | | |
| Doctorate Degree | | | | |
| Total | | | | |

B. Licensed Practical Nurses and Ancillary Nursing Personnel

| LPNs Nurses Aides | Number of Budgeted Vacancies | Number of Positions You Added in the Past 12 Months | Number of Positions You Eliminated in the Past 12 Months |
|---|---|---|---|
| LPN | | | |
| Nurses Aides | | | |

C. Contract Nursing Personnel

Does your organization use contract nursing personnel? ____ Yes ____ No

If yes, indicate the number of contract personnel used in the following categories in the past 12 months

| Category | Number Of Contract Personnel | Number of Positions You Added in the Past 12 Months | Number of Positions You Eliminated in the Past 12 Months |
|---|---|---|---|
| RN | | | |
| LPN | | | |
| Nurses Aides | | | |

## SCHEDULE G – SKILLED CARE PROCEDURES

1. Please report the number of residents receiving the following procedures.

| | Unduplicated Number of Residents |
|---|---|
| MEDICATION | |
| Given by intravenous injections | _____ |
| Given by intramuscular injections | _____ |
| Given by insulin pump | _____ |
| INTRAVENOUS FEEDINGS | |
| IV antibiotic therapy | _____ |
| IV chemotherapy | _____ |
| TUBE FEEDINGS | |
| Gastrostomy | _____ |

## SCHEDULE G – SKILLED CARE PROCEDURES (continued)

| | Unduplicated Number of Residents |
|---|---|
| Jejunostomy | _____ |
| Enteral nutrition | _____ |
| Parenteral nutrition | _____ |
| **RESPIRATORY THERAPY** | |
| IPPB treatments | _____ |
| Oxygen | _____ |
| **WOUND CARE** | |
| Decubitus ulcer care | _____ |
| Sterile dressings with prescription medicines | _____ |
| Wound irrigations | _____ |
| Hemovac care | _____ |
| Diabetic wound care | _____ |
| **CATHETER CARE** | |
| Hickman | _____ |
| Port-a-cath | _____ |
| Subclavian | _____ |
| **ENTEROSTOMY CARE** | |
| Colostomy irrigation and care | _____ |
| Ileostomy care | _____ |
| **GENITAL/URINARY CARE** | |
| Indwelling foley catheter maintenance & care | _____ |
| Bladder irrigations: | |
| Intermittent | _____ |
| Continuous with medication instillation | _____ |
| **PHYSICAL THERAPY** | _____ |
| **OCCUPATIONAL THERAPY** | _____ |
| **SPEECH THERAPY** | _____ |

## SCHEDULE H – ACTIVITIES OF DAILY LIVING (ADL)

1. Number of residents on 12/31 that require assistance with activities of daily living (ADL) (Residents will be duplicated and should be counted in every category that applies).

| | |
|---|---|
| Bathing | _____ |
| Toileting | _____ |
| Dressing | _____ |
| Eating | _____ |
| Transferring (in and out of bed to chair) | _____ |

## SCHEDULE H – ACTIVITIES OF DAILY LIVING (ADL) (Continued)

2. Number of residents on 12/31 by the number of ADL requiring assistance.

Require assistance with 1 ADL _____

Require assistance with 2 ADLs _____

Require assistance with 3 ADLs _____

Require assistance with 4 ADLs _____

Require assistance with 5 ADLs _____

3. Number of residents on 12/31 that require assistance with instrumental activities of daily living (IADL) by number of IADL residents.

(Residents will be duplicated and should be counted in every category that applies).

Money management _____

Shopping _____

Preparing meals _____

Using phones _____

Doing light housework _____

Taking medication _____

4. Number of residents on 12/31 by the number of IADLs requiring assistance.

Require assistance with 1 IADL _____

Require assistance with 2 IADLs _____

Require assistance with 3 IADLs _____

Require assistance with 4 IADLs _____

Require assistance with 5 IADLs _____

## SCHEDULE I – FINANCIAL DATA

Dates covered From _____ To _____

1. Costs: (*exclude all depreciation*) (*round all figures to the nearest dollar*)

| | |
|---|---|
| A. Administration* | _____ |
| B. Payroll | _____ |
| C. Fringe Benefits | _____ |
| D. Contract and Professional Fees | _____ |
| E. Other Operating Costs | _____ |
| F. Non-Operating Costs (include interest, taxes (even though they are listed below), real estate lease, etc.) | _____ |
| G. Total | _____ |

*Include all expenses associated with administration in this item including payroll. Do not duplicate any administrative expenses in the other categories of cost.

H. Taxes (should have been included in 1F.) _____

| 2. Capital Assets | Cost | Market Value | Depreciation Annual | Depreciation Accumulative |
|---|---|---|---|---|
| A. Building & Equipment | | | | |
| B. All other | | | | |
| C. Total | | | | |

| 3. Charges | Gross Resident Charges | minus | Adjustments to Charges | equals | Net Resident Revenue |
|---|---|---|---|---|---|
| A. Self-Pay | | | | | |
| B. Long-Term Care Insurance | | | | | |
| C. Other | | | | | |
| D. Total | | - | | = | |

4. Adjustments to Charges

| | |
|---|---|
| A. Bad Debts | _____ |
| B. Charity Care | _____ |
| C. Nongovernment Contractual | _____ |
| D. Other | _____ |
| E. Total Adjustments | _____ |

5. All Other Revenue _____

6. Total Revenue
[(3D) Total Net Resident Revenue] + [5. All Other Revenue] _____